Policy/Clarification Number: E2003-053

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June 15, 2011

CRITERIA FOR PRIOR AUTHORIZATION

Forteo® (teriparatide)

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug requires prior authorization:
Teriparatide (Forteo®)

CRITERIA for teriparatide: (must meet one of the following)

1. Patient has a diagnosis of drug-induced osteoporosis and has taken oral steroid therapy (see attached table) for at least 90 days in the past 180 days.
   And one of the following:
   a. Patient has a history of osteoporotic fracture.
   b. Patient has failed or was intolerant to previous osteoporosis therapy (see attached table).
   c. Patient has a history of tobacco use in the past 90 days and has a history of being underweight, anorexia, bulimia or amenorrhea.
   d. Patient has multiple risk factors for fracture.

2. Patient is male and has a diagnosis of hypogonadal or idiopathic osteoporosis.
   And one of the following:
   a. Patient has a history of osteoporotic fracture.
   b. Patient has failed or was intolerant to previous osteoporosis therapy (see attached table).
   c. Must have at least 2 of the following:
      i. Patient has at least 90 days of oral steroid therapy (see attached table) in the past 180 days.
      ii. Patient has a history of tobacco use in the past 90 days.
      iii. Patient has a history of being underweight, anorexia, bulimia or amenorrhea.
   d. Patient has multiple risk factors for fracture.

3. Patient is female, 55 years of age or older and has a diagnosis of osteoporosis or is postmenopausal and has a diagnosis of osteoporosis.
   And one of the following:
   a. Patient has a history of osteoporotic fracture.
   b. Patient has failed or was intolerant to previous osteoporosis therapy (see attached table).
   c. Must have at least 2 of the following:
      i. Patient has at least 90 days of oral steroid therapy (see attached table) in the past 180 days.
      ii. Patient has a history of tobacco use in the past 90 days.
      iii. Patient has a history of being underweight, anorexia, bulimia or amenorrhea.
   d. Patient has multiple risk factors for fracture.

Prior authorization may be approved for up to 6 (six) months if total duration of teriparatide (Forteo) therapy has been less than 18 months in the past 2 years. Treatment duration will not exceed 24 months.

Osteoporosis Therapy

Generic Name	Brand Name
Alendronate	Fosamax®
Alendronate/Vitamin D	Fosamax Plus D®
Calcitonin, salmon	Fortical®, Miacalcin®, Calcimar®
Ibandronate	Boniva®
Raloxifene	Evista®
Risedronate	Actonel®, Atelvia®
Risedronate/Calcium Carbonate	Actonel with Calcium®
Zoledronic Acid	Reclast®

Oral Steroid Therapy

Generic Name	Brand Name
Budesonide	Entocort®
Cortisone	Cortone®
Dexamethasone	Decadon®, Dexone®, Hexadrol®, Baycadron®, Dexpak®, Zema-Pak®
Hydrocortisone	Hydrocortone®, Cortef®
Methylpresnisolone	Medrol®
Prednisolone	Prelone®, MilliPred®, OraPred®, VeriPred®, PediaPred®
Prednisolone/Peak Flow Meter	AsmalPred Plus®
Prednisone	Orasone®, SteraPred®, Deltasone®